**PROTOCOL CODE: GIAVCAP**

For other indications or for more than 16 cycles, a BC Cancer “Compassionate Access Program” request form must be completed and approved prior to treatment.

<table>
<thead>
<tr>
<th>DOCTOR’S ORDERS</th>
<th>Ht_________ cm  Wt_________ kg  BSA_________ m²</th>
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**REMINDER:** Please ensure drug allergies and previous bleomycin are documented on the Allergy & Alert Form

- **DATE:**
- **To be given:**
- **Cycle(s) #:**

**Date of Previous Cycle:**
- □ Delay treatment _____ week(s)
- □ CBC & diff, platelets day of treatment

- May proceed with doses as written if within 96 hours ANC greater than or equal to 1.5 x 10⁹/L, Platelets greater than or equal to 75 x 10⁹/L, Creatinine Clearance greater than 50 mL/minute

**Dose modification for:**
- □ Hematology
- □ Age/ECOG
- □ Other Toxicity ____________________

 Proceed with treatment based on blood work from __________________________

**CHEMOTHERAPY:**
- □ Repeat in three weeks

capcitabine 1250 or 1000 mg/m² (circle one) x BSA x (______%) = _________mg PO bid with food x 14 days

(Round dose to nearest 150 mg)

**RETURN APPOINTMENT ORDERS**

- □ Return in three weeks for Doctor and Cycle _________
- □ Return in six weeks for Doctor and Cycle _____ & ______.
- □ Last Cycle. Return in ________ week(s)

**CBC & diff, platelets, creatinine prior to each cycle**

- If clinically indicated: □ BUN  □ Total Protein  □ Albumin  □ Bilirubin
- □ Alk Phos  □ GGT  □ ALT  □ CEA  □ CA 19-9

- □ INR weekly  □ INR prior to each cycle
- □ Other tests:

- □ Weekly Nursing Assessment
- □ Consults:

- □ See general orders sheet for additional requests.

**DOCTOR’S SIGNATURE:**

**SIGNATURE:**

**UC:**